TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
UNIVERSAL DME LLC

MFDR Tracking Number
M4-16-1562-01

MFDR Date Received
February 5, 2015

Respondent Name
EAST TX EDUCATIONAL INS ASSN

Carrier's Austin Representative
Box Number 17

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "It is our understanding that a preauthorization is only required on items that are over $500 per line item in which these are not over that amount. We should be paid for services rendered because we have submitted the appropriate paperwork for review."

Amount in Dispute: $913.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "It is our position that denial based on ODG for the CPM rental should be maintained, the payment previously issued for the approved services was correct and that no further reimbursement is due."

Response Submitted by: Claims Administrative Services, Inc.

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Service(s)	Amount In Dispute	Amount Due
November 24, 2015	E0673 and E0675	$913.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all-applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.600 sets out the Preauthorization, Concurrent Utilization Review, and Voluntary Certification of Health Care.
3. 28 Texas Administrative Code §137.100 sets out the treatment guidelines.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits
   - 197 – Precertification/authorization/notification absent

Issues

1. Did the requestor obtain preauthorization for the disputed services?
2. Is the requestor entitled to reimbursement?

Findings

1. The requestor seeks reimbursement for HCPCS Level II Codes E0673 and E0675. The insurance carrier denied/reduced the disputed services with reduction code "197 – Precertification/authorization/notification absent."

   The requestor, in their position summary states, "It is our understanding that a preauthorization is only required on items that are over $500 per line item in which these are not over that amount. We should be paid for services rendered because we have submitted the appropriate paperwork for review."

   28 Texas Administrative Code §134.600 (p) (9) states in pertinent part, "(p) Non-emergency health care requiring preauthorization includes: (9) all durable medical equipment (DME) in excess of $500 billed charges per item (either purchase or expected cumulative rental)..." The requestor submitted a bill with each line item under the $500.00 threshold, as a result, 28 Texas Administrative Code §134.600 (p) (9) does not apply to the disputed services as they are under the $500.00 threshold.

   28 Texas Administrative Code §134.600 (p) (12) states in pertinent part, "(p) Non-emergency health care requiring preauthorization includes: (12) treatments and services that exceed or are not addressed by the commissioner's adopted treatment guidelines or protocols and are not contained in a treatment plan preauthorized by the insurance carrier. This requirement does not apply to drugs prescribed for claims under §§134.506, 134.530 or 134.540 of this title (relating to Pharmaceutical Benefits)..." The disputed services are under $500.00 per line item and are not addressed in 28 Texas Administrative Code §134.600(p), as a result the disputed charges are subject to 28 Texas Administrative Code §134.600 (p) (12).

   28 Texas Administrative Code §137.100 "(a) Health care providers shall provide treatment in accordance with the current edition of the *Official Disability Guidelines - Treatment in Workers' Comp,* excluding the return to work pathways, (ODG), published by Work Loss Data Institute (Division treatment guidelines), unless the treatment(s) or service(s) require(s) preauthorization in accordance with §134.600 of this title (relating to Preauthorization, Concurrent Review and Voluntary Certification of Health Care) or §137.300 of this title (relating to Required Treatment Planning." The insurance carrier submitted sufficient documentation, a copy of the Official Disability Guidelines (ODG) section, to support, that the disputed services are subject to preauthorization. Review of the documentation submitted by the requestor does not support that preauthorization was obtained as required by 28 Texas Administrative Code §134.600 (p) (12). As a result, the requestor is not entitled to reimbursement.
2. Review of the submitted documentation finds that the requestor is not entitled to reimbursement for HCPCS Level II Codes E0673 and E0675 rendered on November 24, 2015.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	February 18, 2016 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.